

**INDIVIDUAL PARTICIPANT PERMISSION FORM**

PARENT/GUARDIAN AUTHORIZATIONS Required of all participants.

I hereby give permission for my child/ward \_\_\_\_\_ to participate in the **First Call Retreat at Bishop Lane Retreat Center, July 15 - 18, 2018**. I hereby release and indemnify the Diocese of Rockford, its staff and volunteers, all participating parishes and the Catholic Bishop of Rockford from any and all liability arising from claims of any kind or nature whatsoever from my child's participation in this program. I understand my child/self maybe photographed/video taped for promotion and coverage of this program by the Diocese of Rockford, as part of their participation, and I give permission for this.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

*\*The purpose of this event is vocation awareness.*

**MEDICAL PERMISSION FORM & INSURANCE INFORMATION**

I grant permission for the administration of first aid to my child \_\_\_\_\_ by the people in charge of the program and those transporting my child to and from the program as their judgement deems advisable, and to make the necessary referrals to qualified physicians for treatment of illness or accidents of a more serious nature. I understand that I will be promptly notified in the event of any illness or accident and prior to any major surgery, except when delay in such communication would endanger life. In case of medical emergency, I understand that every effort will be made to contact the parents(guardians) of the participant. In the event I cannot be reached I hereby give permission to the physician selected by the adult staff to hospitalize, secure proper treatment for, and to order injection, anesthesia or surgery, if deemed necessary for my child. The undersigned shall be liable and agree(s) to pay all costs and expenses incurred in connection with such medical and dental services rendered to the aforementioned child pursuant to this authorization.

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Child's Physician

\_\_\_\_\_  
Physician's Phone Number

**INSURANCE INFORMATION**

\_\_\_\_\_  
Insurance Company

\_\_\_\_\_  
Policy in the Name of:

\_\_\_\_\_  
Policy Number

\_\_\_\_\_  
I.D. # or Social Security #

Please list any allergies or special medical problems your child may have.

Should it be necessary for our (my) child to return home due to medical reasons or discipline problems, the undersigned will be called and expected to pick up the child or make arrangements for the child to be picked up immediately.

\_\_\_\_\_  
Signature of Parent/Guardian                      Date

Note: In cases of custody agreement, permission form must be signed by parent(s) who has (have) custody currently.

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### Vocation Camp Registration Form

1. Please also complete the [Permission Form below](#) and mail both in as soon as possible.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

T-Shirt Size \_\_\_\_\_

Phone #: \_\_\_\_\_

Parish: \_\_\_\_\_

School: \_\_\_\_\_

Grade entering: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Email: \_\_\_\_\_

#### Health History

1. Does your child have any health or other problems we should know about? Please explain:

\_\_\_\_\_  
\_\_\_\_\_

2. Does your child take any medication? If so, what type, what is it for, when is it taken, who would you like to be responsible for its administration (your child or our staff)?

\_\_\_\_\_  
\_\_\_\_\_

3. In case of an emergency, please list two or three people and phone numbers for contact:

Name: \_\_\_\_\_ Phone #'s: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #'s: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #'s: \_\_\_\_\_

Amount

Enclosed

4. Registration fee: \$90.00

Please mail to: Vocation Office – 555 Colman Center Drive. – Rockford, IL, 61125.

For more information or questions contact the Vocation office:

Phone: 815-399-4300. E-mail: [vocations@rockforddiocese.org](mailto:vocations@rockforddiocese.org)

**MAKE CHECKS PAYABLE TO: VOCATION OFFICE**